Progestogen Supplementation during Luteal Phase in the Treatment of Infertility in the First Trimester

Manish R Pandya1*, Chirag Amin2, Ganpant Sawant3, Sunita Chandra4, Vasundhari Mandi5 and Suman Lal6

1Mahavir Hospital, Surendranagar, Gujarat, India
2Amin’s Hospital, Ahmedabad, Gujarat, India
3D Y Patil Medical College, Mumbai, Maharashtra, India
4Rajendra Nagar Hospital, Lucknow, Uttar Pradesh, India
5Sanjeevni maternity and infertility hospital, Raichur, Karnataka, India
6Max hospital, Gurgaon, Haryana, India

*Corresponding author: Manish Pandya, Scientific Research Institute, Surendranagar – 363001, India, Tel: 9825223816; Email: drmanish.pandya@gmail.com

Abstract

Aim: The aim of present review is to provide a comprehensive view of the literature regarding the clinical efficacy and safety effects of supplementation of Progestogens during luteal phase in the first trimester.

Methods: A literature search was performed using electronic databases like Pubmed/Medline to identify from 1980 to 2015. The search yielded around 27 original studies and review articles. The search yielded around 31 clinical studies and reviews.

Results: Progestogen use for luteal support in assisted reproductive technologies is associated with significantly higher rates of live birth or ongoing pregnancy than placebo or no treatment. Based on findings from randomized control studies and meta-analysis, similar ongoing pregnancy and miscarriage rates have been observed for dydrogesterone (oral) when compared to intra-vaginal micronized progesterone (MCP) and between MCP intra-vaginal and MCP intra-muscular for luteal phase support. However, dydrogesterone (oral) exhibited an overall higher ongoing pregnancy rate compared to MCP oral (30% vs. 11%). There was no evidence to indicate that maternal exposure to Progestogens during pregnancy increased the risk for birth defects.

Conclusion: The relative effectiveness, safety, optimal route and duration of oral, vaginal, and intra-muscular progestogen formulations is a topic of ongoing debate. Future investigations with longer follow-ups and larger sample sizes comparing different routes of administration, dosages, and timing of administration are warranted.

Keywords: Progestogens; Infertility; Luteal Phase Support; Luteal Phase Defect; In-vitro Fertilization; Intra-Uterine Insemination
Introduction

Infertility is an important condition in reproductive medicine with physiologic, economic, demographic and medical implications. It is clinically described as inability of a person or a couple to conceive after one year of unprotected intercourse or inability of the female to carry pregnancy to term [1]. Infertility is called 'primary infertility' if the woman is unable to ever become pregnant or to carry a pregnancy to a live birth. If a woman is not able to bear a child following a previous pregnancy or a pregnancy leading to a live birth, it is termed as 'secondary infertility' [2]. In India the infertility rate is reported to be about 8% [3,4]. In most cases, the etiology is distributed fairly equally among male factors, ovarian dysfunction, and tubal factors. A smaller percentage of cases are attributed to endometriosis, uterine or cervical factors, or other causes. However, in approximately one fourth of couples, the cause is uncertain and is referred to as “unexplained infertility” [5].

The first step of treating infertility is to treat the underlying cause of infertility, on the basis of which varied categories of treatment options are available such as medications; surgical treatments, and assisted reproductive technology (ART) [6]. Various factors, including pituitary down regulation with gonadotropin-releasing hormone (GnRH) agonist, administration of HCG for final oocytes maturation, and aspiration of follicular fluid in ART may alter the estrogen/progesterone ratio, resulting in luteal phase defect [7-9]. Studies have established that luteal function is compromised in in-vitro fertilization (IVF) cycles wherein the absence of luteal phase support (LPS) leads to premature luteolysis and early bleeding thereby, resulting in a significant reduction in pregnancy rates [10-14]. Hormone supplementation becomes utmost crucial during ART as the use of GnRH agonist or GnRH antagonists for pituitary down regulation disturbs the normal progesterone production [10]. Progesterone supplementation during the luteal phase of the IVF cycles improves clinical pregnancy outcomes significantly as compared to cycles without treatment [15]. Progesterone is usually the drug of choice for luteal support as progesterone produced by corpus luteum activates a cascade of molecular events that renders the endometrium receptive to implantation and potentially sustains the survival of the embryo [16-18]. Over the past few years progesterone supplementation has been extensively investigated to overcome LPD in IVF cycles [19,20]. Available products include both ‘synthetic’ and ‘natural’ progesterone which can be administered orally, intramuscularly (IM), rectally, or intra-vaginally (IV) for LPS [15,21]. The aim of this descriptive review is to provide an overview of current scientific evidence, summarizing the clinical efficacy and safety of progestogens available for LPS during intra-uterine insemination (IUI) and IVF cycles in the first trimester.

Methods

A literature search was performed using electronic databases such as Pubmed/Medline to identify relevant articles using relevant search terms for Progestogens, infertility, LPS, ART, IUI and IVF. From this search, publications that met the following criteria: original contributions of Progestogens with relevant product names, randomized control trials, observational studies, along with the review articles, systematic reviews and meta-analyses and reports limited to clinical human data that were published in the English language were included in the review. Case reports and case series were not included in the review. All articles considered were published in the scientific literature. Full text articles of relevant abstracts were assessed and evaluated. The search yielded around 31 original studies (randomized controlled, open and observational), systematic reviews and meta-analysis evaluating clinical efficacy and/or safety of Progestogens in management of infertility which were reviewed and are included in the subsequent sections below.

Results

Role of Progestogens in Intra-Uterine Insemination (IUI)

IUI is considered to be an intermediate step before application of sophisticated assisted reproductive techniques like IVF [22]. Following IUI, Progestogens are prescribed to supplement the luteal phase to facilitate better implantation of the embryo and sustenance of pregnancy in ART [23]. A recent randomized double blind clinical trial among 150 infertile women undergoing IUI, demonstrated significantly higher serum progesterone levels in patients treated with oral dydrogesterone compared to intra-vaginal MCP (52.6±29.9 versus28.9±15.9, p=0.001) [24]. A lower abortion rate was observed for the dydrogesterone group compared to the vaginal MCP group (9.1% versus 15.8%), however, this finding was not statistically significant (p=0.056) [24]. Overall satisfaction rate was significantly higher in dydrogesterone group compared to vaginal MCP (85.1%
versus 60.8%, p<0.001) [24]. Similarly, an open-label prospective study among 78 women reported higher pregnancy rates in dydrogesterone group compared to oral micronized progesterone (30% versus 11%) which can be attributed to increased mid luteal progesterone level (30.7 ng/ml versus 20.6 ng/ml) that contributes in the sustenance of the pregnancy [25]. Furthermore, safety and tolerability of oral, intra-vaginal micronized progesterone, and oral dydrogesterone has been observed to be similar with limited serious adverse events or birth defects reported [25,26]. However, findings from a meta-analysis of five RCTs, reports multiple pregnancies in the intra-vaginal progesterone group (13 events of 951 cycles) as well as miscarriages (68 miscarriages of 951 cycles) compared to the no progesterone group (multiple pregnancy 12 events and miscarriages 52 of 951 cycles) [27].

### Role of Progestogens in in-vitro fertilization cycles (IVF)

For luteal support in ART, exogenous progesterone is associated with a significantly higher pregnancy rate than placebo or no treatment. Findings from randomized comparative studies published in recent literature have also demonstrated similar clinical efficacy for both oral dydrogesterone and intra-vaginal MCP in IVF cycles indicating that these medications, when compared with each other, show no significant difference in successful clinical pregnancy rates [28-32] (Table 1). Currently available formulations of progesterone include oral, rectal, intra-vaginal, and intra-muscular.

<table>
<thead>
<tr>
<th>Author</th>
<th>Study Design</th>
<th>Study Sample</th>
<th>Treatment Arms</th>
<th>Clinical Efficacy Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chakravarty et al. 2005 [28]</td>
<td>Prospective randomized comparative study</td>
<td>430</td>
<td>Dydrogesterone versus vaginal micronized progesterone</td>
<td>Viable delivery: 24.1%</td>
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<td>Viable delivery: 22.8%</td>
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<td>Miscarriage: 7.6%</td>
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<td>Miscarriage: 8.3%</td>
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<td>Ongoing pregnancy rate:30.0%</td>
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<td>Ongoing pregnancy rate:30.0%</td>
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<td>Implantation: 22.0%</td>
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<td>Multiple pregnancy rate: 5.30%</td>
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<td>Multiple pregnancy rate: 7.20%</td>
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<td>Miscarriage rate: 5.0%</td>
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<td>Miscarriage rate: 3.0%</td>
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<tr>
<td>Saharkhiz et al. 2005 [29]</td>
<td>Randomized comparative study</td>
<td>210</td>
<td>Dydrogesterone versus vaginal micronized progesterone</td>
<td>Ongoing pregnancy rate: 30.3%</td>
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<td>Ongoing pregnancy rate: 28.1%</td>
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<tr>
<td>Tomic et al. 2015 [30]</td>
<td>Randomized control trial</td>
<td>853</td>
<td>Dydrogesterone versus vaginal micronized progesterone</td>
<td>Pregnancy rate: 28.67%</td>
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<td>Vaginal micronized progesterone (gel)</td>
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<td>Miscarriage rate: 11.57%</td>
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<td></td>
<td>Pregnancy rate: 28.63%</td>
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<td>Miscarriage rate: 13.04%</td>
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<td>Vaginal micronized progesterone (capsule)</td>
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<tr>
<td>Ganesh et al. 2011 [31]</td>
<td>Prospective randomized study</td>
<td>1,373</td>
<td>Dydrogesterone versus vaginal micronized progesterone (gel) versus vaginal micronized progesterone (capsule)</td>
<td>Clinical pregnancy rate: 25%</td>
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<td>Clinical pregnancy rate: 32.5%</td>
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<td>Miscarriage: 7.5%</td>
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<td>Miscarriage: 7.7%</td>
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<tr>
<td>Salehpour et al. 2013 [64]</td>
<td>Prospective, single blinded, randomized clinical trial</td>
<td>80</td>
<td>Dydrogesterone versus vaginal micronized progesterone</td>
<td>Clinical pregnancy rate: 25%</td>
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<td>Clinical pregnancy rate: 32.5%</td>
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<td>Miscarriage: 7.5%</td>
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<td>Miscarriage: 7.7%</td>
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</table>
Barbosa et al.  2015 [32] | Review & Meta-analysis | Ongoing pregnancy: N=3,134 women | Clinical pregnancy: N=3,809 women | Dydrogesterone versus vaginal progesterone | No significant difference observed between oral dydrogesterone and vaginal progesterone

Domitz et al. 1999 [65] | Retrospective study | 518 | Dydrogesterone versus intramuscular progesterone | Similar pregnancy rate, implantation rate and spontaneous abortion rate observed in both the groups

### 17-Hydroxyprogesterone caproate (17-OHPC)

<table>
<thead>
<tr>
<th>Study</th>
<th>Study Design</th>
<th>Sample Size</th>
<th>Intervention</th>
<th>Outcome Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abate et al. 1997 [50]</td>
<td>Randomized comparative study</td>
<td>80</td>
<td>17-OHPC versus intramuscular progesterone</td>
<td>Clinical pregnancy: 44.7%</td>
</tr>
<tr>
<td>Costabile et al. 2001 [43]</td>
<td>Prospective randomized study</td>
<td>300</td>
<td>17-OHPC versus intramuscular progesterone</td>
<td>Clinical pregnancy: 43.3%</td>
</tr>
<tr>
<td>Moini et al. 2011 [51]</td>
<td>Prospective randomized study</td>
<td>103</td>
<td>17-OHPC versus intramuscular progesterone</td>
<td>Ongoing pregnancy: 24.5%</td>
</tr>
<tr>
<td>Abate et al. 1999 [50]</td>
<td>Randomized study</td>
<td>86</td>
<td>17-OHPC versus placebo</td>
<td>Pregnancy rate: 32.5%</td>
</tr>
<tr>
<td>Abu-Musa et al. 200866</td>
<td>Randomized control study</td>
<td>125</td>
<td>17-OHPC versus control</td>
<td>Clinical pregnancy: 34.9%</td>
</tr>
<tr>
<td>Unifer et al. 2004 [52]</td>
<td>Prospective randomized study</td>
<td>320</td>
<td>17-OHPC versus vaginal progesterone</td>
<td>17 OH-PC is found to be more effective in IVF-embryo transfer cycles compared to vaginal progesterone.</td>
</tr>
<tr>
<td>Satir F et al. 2013 [53]</td>
<td>Retrospective single centre study</td>
<td>927</td>
<td>17-OHPC versus intravaginal micronized progesterone</td>
<td>Clinical pregnancy rate:</td>
</tr>
</tbody>
</table>

#### Table 1: Clinical efficacy of progestogens.

Several clinical trials have demonstrated that among the different routes of progesterone administration, the intra-vaginal route is considered to be more effective than the IM or oral route. In most ART centers worldwide the use of intra-vaginal Progestogen has become routine practice, however, several research papers also report that intra-vaginal route is not very well accepted due to side effects such as vaginal irritation and discharge [33].
Route of Progestogen administration

**Oral administration:** Oral MCP was commonly used for luteal support in IVF cycles during the late 1980’s however, the results observed with its use have been poor due to absence of secretory transformation of the endometrium in patients with premature ovarian failure who had been treated with oral MCP when compared with IM injections or intra-vaginal MCP [34]. This finding suggested that oral administration of MCP had possibly reduced the hormone’s bioavailability. Additionally, a randomized prospective clinical trial among 43 women undergoing IVF who were treated with oral MCP and progesterone (IM) reported lower clinical pregnancy rates (45.8% versus 57.9%) and implantation rates (18.1% versus 40.9%) for the oral MCP group. Thereby indicating that oral MCP is less effective compared to progesterone (IM) [35].

To overcome this problem, dydrogesterone, a retro-progesterone, through its preferential affinity for progesterone receptor, has a better potential to generate endothelial nitric oxide synthases (ENO) and release nitric oxide, thereby enhancing endometrial vascularity similar to natural progesterone [36]. The chemical configuration of dydrogesterone makes it metabolically stable and orally effective, as compared to intra-vaginal micronized progesterone [37]. Moreover, mean serum progesterone levels have also been reported to be higher when patients are given oral dydrogesterone than with intra-vaginal progesterone [38]. This is supported by a phase II randomized controlled study involving 675 patients undergoing ART (divided into 3 groups) randomized between dydrogesterone 30mg/day and intra-vaginal MCP 600mg/day that reported significantly higher pregnancy rates with dydrogesterone than with intra-vaginal MCP in all the three groups. (39.1% versus 26.7%; p<0.01, 41.2% versus 35.6%; p<0.01 and 48.2% versus 33.9%; p<0.001) [39].

Similar results were obtained from a randomized comparative study among 430 women undergoing IVF/ICSI, that reported comparative pregnancy and miscarriage rates with oral dydrogesterone and intra-vaginal MCP (24.1% versus 22.8%; 7.6% versus 8.6%), respectively [37]. A recent meta analysis also reported no difference in ongoing pregnancies (RR 1.04, 95% CI 0.92 to 1.18, I(2) = 0%, 7 RCTs, 3,134 women), clinical pregnancies (RR 1.07, 95% CI 0.93 to 1.23, I(2) = 34%, 8 RCTs, 3,809 women), and miscarriages (RR 0.77, 95% CI 0.53 to 1.10, I(2) = 0%, 7 RCTs, 906 clinical pregnancies) between oral dydrogesterone and intra-vaginal progesterone [32]. Furthermore, findings from a prospective randomized study conducted among 1,373 Indian women undergoing IVF/ICSI indicated comparable pregnancy rates among oral dydrogesterone, intra-vaginal MCP gel and intra-vaginal MCP capsule (28.67%, 28.63%, and 22.65% respectively). Also, comparable miscarriage rates were observed among the three groups (11.57%, 13.04% and 18.26% respectively) [31]. These findings are further supported in two other randomized comparative studies that have reported similar pregnancy and miscarriage rates between women receiving oral dydrogesterone and intra-vaginal MCP [29,30]. Thus based on the findings of these studies it can be concluded that oral dydrogesterone as luteal support in IVF is equally effective as intra-vaginal MCP.

**Intra-vaginal and Intramuscular administration:** The relative effectiveness of intra-vaginal and IM routes of progesterone supplementation has been controversial. The intra-vaginal route of progesterone supplementation in IVF has gained wide application as a first choice of luteal support regimen, mainly due to its clinical effectiveness. Following intra-vaginal administration of progesterone, high uterine progesterone concentrations with low peripheral serum values are observed due to uterine first pass effect where liver metabolism is absent [40-42]. With IM progesterone; supplementation is given as an injection of natural progesterone in oil. However, this route is associated with a number of local side effects, including pain, inflammatory reactions, and abscesses at the site of injection, causing a lack of enthusiasm for this treatment modality [43]. In addition, many reports have been published in which patients receiving IM progesterone have developed acute eosinophilic pneumonia [44, 45]. These drug induced conditions show that the use of IM progesterone can be associated with morbidity in otherwise healthy women.

A clinical trial involving 250 women in a first IVF cycle, randomized to receive IM progesterone or intra-vaginal micronized progesterone observed higher pregnancy rates in the group treated with IM progesterone [46]. A second open label randomized trial involving 201 women yielded similar results with age adjusted odds ratio for clinical pregnancy, implantation, and live birth rates favoring the IM progesterone treatment arm as opposed to the intra-vaginal (gel) progesterone arm [47]. In contrast, an open-label trial with 1,184 women from 16 US centers between intra-vaginal and IM progesterone reported comparable clinical (35.1% versus 35.2%,
respective) and ongoing pregnancy rates (30.2% versus 33.6%, respectively) between the two treatment groups. Similarly, a retrospective cohort study among 544 women treated with intra-vaginal MCP and progesterone (IM) reported no significant differences in the rate of clinical pregnancies (49% versus 53%), on-going pregnancies (44% versus 47%), miscarriages (8% versus 10%) and implantations (30% versus 29%) [48]. Findings from a meta-analysis analyzing data from four studies published in 2010 comparing IM progesterone versus intra-vaginal progesterone in 1,222 women undergoing IVF cycles reported no difference in live-birth rate with an odds ratio of 0.85 (95% CI 0.66-1.10) On the basis of presented recent evidence, intra-vaginal administration of progesterone can be considered as a viable alternative to IM progesterone injections as luteal support [49].

Another progesterone, 17 alpha-hydroxyprogesterone caproate (17 OH-PC) administered intramuscularly for luteal phase support is commonly used and has shown better pregnancy rates as compared to IM progesterone [50]. This is supported by findings from two prospective randomized studies which reported higher pregnancy rates and lower abortion rates in 17 OH-PC groups compared to the IM progesterone group [43, 51]. In addition, when 17 OH-PC IM was compared to intra-vaginal progesterone it showed similar to slightly better efficacy at providing luteal support [52,53]. Overall, 17 OH-PC IM is better or equally effective in providing LPS as compared progesterone IM and intra-vaginal progesterone though findings were not statistically significant.

**Rectal administration:** Finally, there are a number of publications that have evaluated the rectal use of natural progesterone in women undergoing IVF [54,55]. Chakmakijan and Zachariah (1987) studied the bioavailability of micronized progesterone by measuring sequential serum progesterone concentrations after a single bolus of 50 – 200 mg given sublingually, orally (capsule and tablet), vaginally and rectally (suppositories) during the follicular phase of a group of normally menstruating women. When compared with other modes of administration, rectal application resulted in serum concentration during the first 8 h twice as high as other forms. However, to the best of our knowledge, there are no prospective randomized trials to compare the rectal administration of progesterone with other administration routes for IVF.

**Overall safety profile of progestogens in IVF:** Several studies have reported good patient compliance and fewer side effects with oral dydrogesterone, when compared to intra-vaginal micronized progesterone [28,31] (Table 2). Findings from a recent randomized control trial report significantly higher overall satisfaction and tolerability with oral dydrogesterone when compared with intra-vaginal progesterone gel [27]. Additionally, no birth defects have been observed with the use of dydrogesterone [56, 57]. Intra-vaginal progesterone gel has been reported to lead to vaginal bleeding, interference with coitus and local adverse effects such as vaginal irritation and discharge [28]. Oral micronized progesterone when compared with intra-vaginal progesterone leads to fatigue, dizziness, headaches, faintness and urinary frequency [58]. Furthermore, intramuscular progesterone includes several complications such as sterile abscesses, bleeding into the muscle and pain at injection site [59]. Therefore, oral dydrogesterone can be considered a safe and efficacious alternative to intra-vaginal and IM progesterone as luteal phase support in ART.

<table>
<thead>
<tr>
<th>Author</th>
<th>Study Design</th>
<th>Study Sample</th>
<th>Treatment Arms</th>
<th>Safety Profile Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chakravarty et al. 2005 [28]</td>
<td>Prospective randomized comparative study</td>
<td>430</td>
<td>Dydrogesterone vs. vaginal micronized progesterone</td>
<td>No vaginal irritation and discharge with dydrogesterone</td>
</tr>
<tr>
<td>Ganesh et al. 2011 [31]</td>
<td>Prospective randomized, single-blinded comparative study</td>
<td>1,373</td>
<td>Dydrogesterone vs vaginal micronized progesterone</td>
<td>Patient compliance, vaginal irritation and discharge can be avoided with dydrogesterone</td>
</tr>
<tr>
<td>Queisser-Luft, 2009 [57]</td>
<td>Retrospective observational study</td>
<td>28</td>
<td>Dydrogesterone alone</td>
<td>No congenital malformation associated with dydrogesterone observed</td>
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<tr>
<td>Balasch et al. 1982 [56]</td>
<td>Randomized comparative study</td>
<td>44</td>
<td>Dydrogesterone vs. vaginal progesterone</td>
<td>No congenital malformations noted</td>
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</table>
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Arafat et al. 1988 [67] Unknown 8 Oral micronized progesterone alone Sedative, hypnotic effect

Norman et al. 1991 [58] Randomized trial 10 Oral micronized progesterone Fatigue, dizziness, headaches, faintness and urinary frequency, mild side effect related to central nervous system

Tomic et al. 2014 [30] Randomized control trial 853 Vaginal progesterone vs. dydrogesterone Vaginal bleeding, interference with coitus, vaginal irritation and discharge

Ng et al. 2007 [68] Randomized trial 132 Vaginal progesterone suppositories vs. vaginal progesterone tablet Perineal irritation, yeast infection

Check et al. 2009 [59] Review - Intramuscular progesterone in oil Sterile abscesses, bleeding into the muscle and pain at injection site [58]

Table 2: Safety profile of progestogens.

Conclusion

Progesterone production from the corpus luteum is critical for natural reproduction. Luteal phase deficiency in natural cycles is a plausible cause of infertility and pregnancy loss, though there is no adequate diagnostic test to detect this. Progesterone supplementation is an important aspect of assisted reproductive technology treatment and has demonstrated clinical benefits in promoting fertility, preventing miscarriages and even preventing pre-term labor [58]. Available evidence from the literature suggests that the most common forms of progesterone supplementation are safe to be used in early pregnancy. The FDA conducted a thorough review of the relevant published studies, and they found that there is no increase in congenital anomalies including genital abnormalities in male or female infants resulting from maternal exposure to progesterone or 17 α-hydroxyprogesterone in early pregnancy [60]. Though there are several guidelines that recommend the use of progesterone as luteal phase support in ART, the route of administration that leads to optimal pregnancy outcomes remains a subject of ongoing debate. Progestogens have different pharmacokinetic and pharmacodynamic properties when used in different routes of administration. Although intramuscular progesterone in oil generates high serum levels of progesterone, intravaginal administration results in very high local progesterone concentration in endometrial tissue [40-42]. While different researchers have made conclusions about the superiority of intramuscular or intra-vaginal progesterone, a recent Cochrane systematic review of clinical trials concluded that with IVF cycles, similar pregnancy rates were observed with intramuscular or intra-vaginal routes of progesterone administration [49]. The similar efficacy of intra-vaginal and IM progesterone, combined with patient preference and lower side effect profile of intra-vaginal progesterone supplementation over IM in IVF cycles, explains the increasing popularity of intra-vaginal supplementation [61].

Oral progesterone as luteal support is also gaining popularity in ART, due to its ease of administration, good pharmacokinetic /bioavailability profile, comparable pregnancy rates, fewer local side effects, and better patient convenience compared with intra-vaginal micronized progesterone. These findings have been supported in recent meta-analysis and randomized controlled studies [32,37,39]. In addition, dydrogesterone is the only drug that has been approved for use in several indications that include but are not limited to threatened miscarriage, recurrent miscarriage, infertility due to luteal deficiency, etc [62,63].

In conclusion, based on review of the current literature, intra-vaginal progesterone and oral dydrogesterone have shown to be clinically effective and safe as luteal supplementation in IVF cycles. However, much of the current scientific evidence is based on reviews and meta-analyses of observational studies and on few RCTs, therefore future investigations with longer follow-ups and larger sample sizes comparing different routes of administration, dosages, and timing of administration are warranted.

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